Accident / Incident Report Closed

Unit/Department	Process Area	Site	Report Number
South Operation-Elyria	General Catalyst – Building 9	ELYRIA	0084-SOPS-15-0057
Report Date	Incident Date	Incident Time	Copied From
05/06/2015	05/05/2015	09:00 PM	
Incident Location		Team Leader / Supervisor	Reported By
Building #9 at the PK Blender discharge station		REDACTED - PERSONAL INFORMATION	
Title of Event (Limit to 90 characters)		Category	Division / Bus. Group / Subgroup Code
Operator was exposed to chrome/aluminum dust while unloading the PK Blender		☐ Safety & Health ☐ Environmental	CC / G-CCP

Incident Classification

☐ Near Miss	☐ Property Loss	☐ Contractor
☐ Process Safety	☐ Citation / NOV	☐ Contractor Injury / Illness
☐ Injury / Illness	☒ Health Exposure	☐ Contract Injury / Illness
☐ Spill / Release	☐ Inspection	☐ PSM
☐ Permit / Regulatory Deviation	☐ Major Incident	☐ Plant Upset
☐ Fire	☐ Non-Occupational	☐ EHS Management System Failure
☐ Odor Complaint	☐ RMP	☐ Other

Describe Event / What Happened

While operating the PK blender in Building #9, the operator was discharging the blender into a sack and was exposed to Oxyvinyls Catoxid 5 impregnation. He was attempting to lift up the neck of the bag in order to clear out a powder build up in the discharge chute, and had the clamp for the neck off. When he let go of the neck a puff of material came out of the bag coating his PAPR and the exposed side of his face as well as the upper part of his Tyvek suit. He called his floor CRT to come and take a look and then vacuumed off and showered. Later in the night the operator noticed that the areas of his neck that had been exposed broke out in a rash which went away overnight.

Immediate Corrective Action or Response

Reattached the bag neck and cleaned up exposed skin and PAPR.

Immediate Cause

Accidental overfilling of Sack caused unnecessary exposure

Cause Narrative

Operator overfilled the bag that he was unloading into due to discharge valve not fully closing.

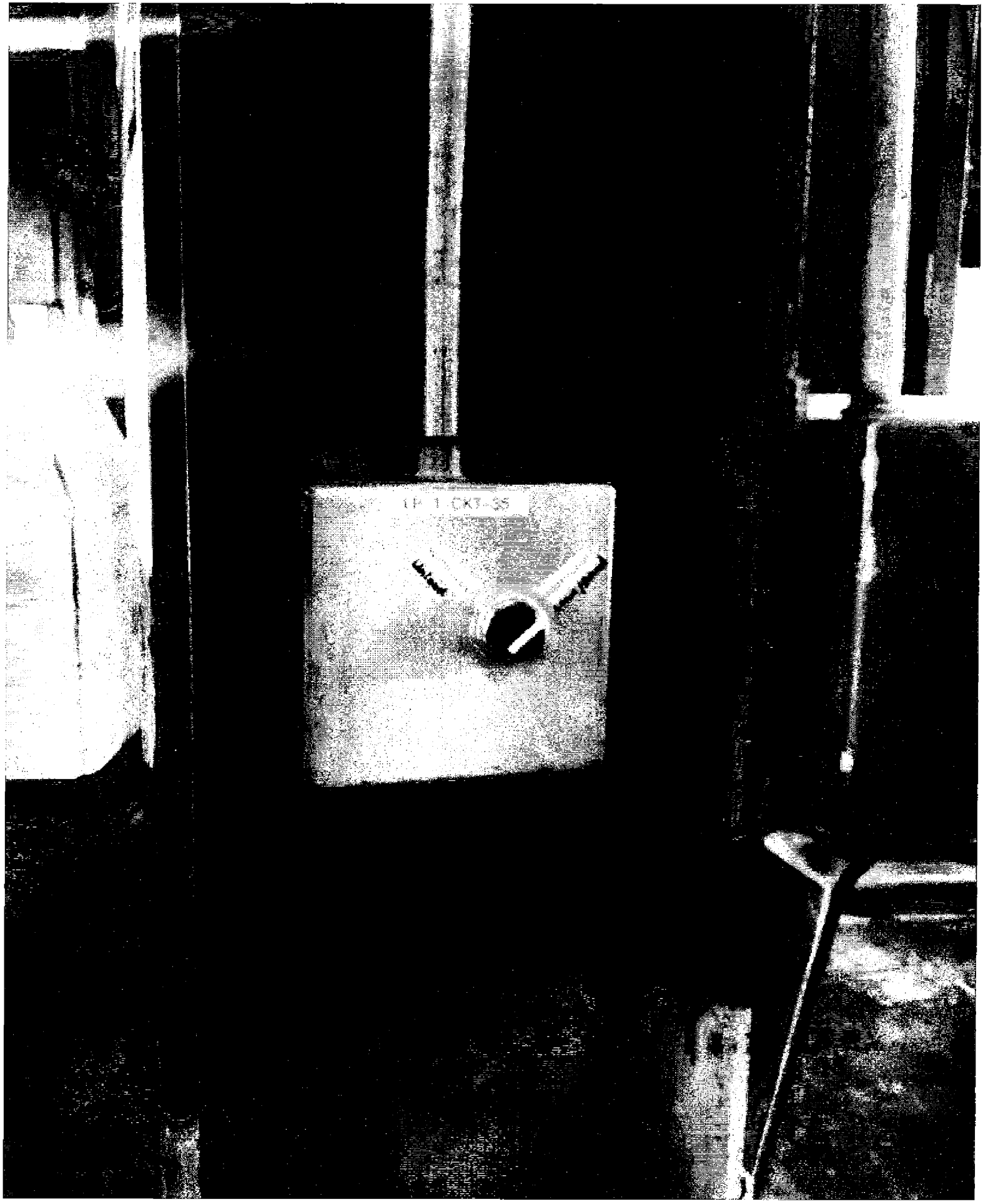
Contributing Causes	Root/Primary Causes		
Discharge valve did not close properly causing material to leak from the blender.	138 - Human Factors Engineering	160 - Intolerant System	161 - Errors Not Detectable
Operator exposed himself to chemicals by removing an exposure safety system, because of an acidental over filling of his bag.	163 - Training	170 - Training LTA	179 - Abnormal Events/Emergency Training LTA

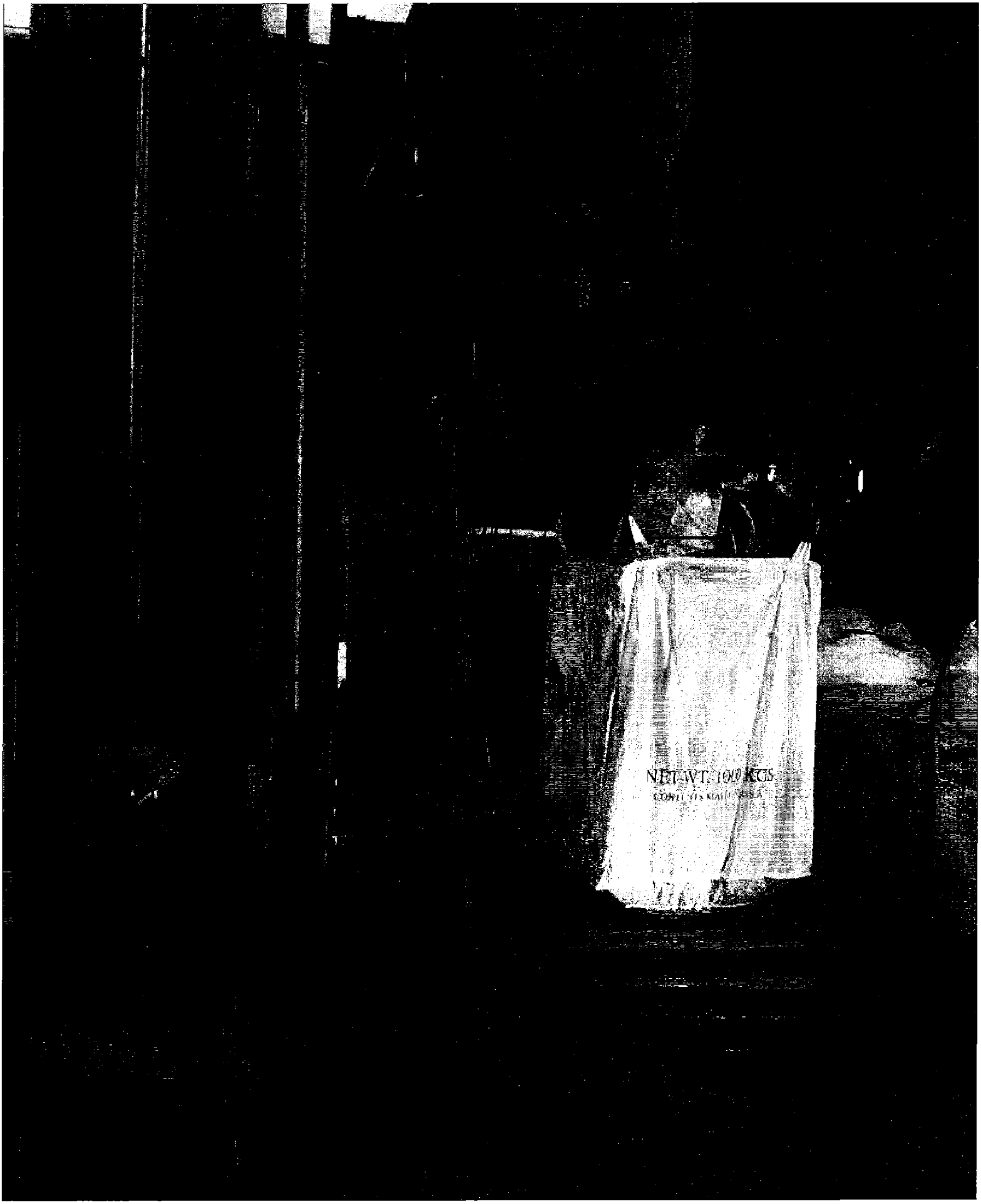
Any known or potential off-site impacts?	No	PSM Incident?	No	Estimated Cost:	1,000.00 USD
Investigation Team	REDACTED - PERSONAL INFORMATION				

Item	Corrective Action(s) to prevent recurrence	Responsible Person	Target Date	Final Closed Date	VC Req	VE Req
1	Replace discharge valve of PK blender.	REDACTED - PERSONAL INFORMATION	09/30/2015	09/28/2015	N	N
2	Review process safety for abnormal process events and emergencies in upcoming safety meeting.		09/30/2015	09/25/2015	N	N

3	Determine a better way to unload bag to prevent overfill	REDACTED - PERSONAL INFORMATION	09/23/2015	06/30/2015	N	N

Approved By:		
Manager / Dept. Head	REDACTED - PERSONAL INFORMATION	5/23/2015 01:52 AM
EHS Unit Coordinator		5/22/2015 11:29 AM

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